# MONTANA MEDICAID Rx FORM

## PATIENT INFORMATION AND Rx

| Patient Name ☐ *Mail to Patient* | Birth Date | Exam Date | Invoice Number |
|---|---|---|---|
| | / / | | |
| Address Street | PIC Number | ICD-9DX Code | Order Date |
| | | | |
| City State Zip | Medicaid ID No. | Date Received | Date Shipped |
| | | | |

| | Sphere | Cylinder | Axis | Prism/Base | Decenter | Distant PD | Near PD |
|---|---|---|---|---|---|---|---|
| R | | | | | | | |
| L | | | | | | | |

| | Add | Near Inset | Total Inset | Seg. Height | OC Height | Center Thickness | Edge Thickness | |
|---|---|---|---|---|---|---|---|---|
| R | | | | | | | | ☐ |
| L | | | | | | | | |

## LENS INFORMATION

| Material | Lens Style | Seg Style | Base Curve | |
|---|---|---|---|---|
| ☐ *Plastic* | ☐ *SV:* | | R | |
| ☐ *Glass* | ☐ *Bifocal:* | | L | |
| ☐ *High Index* | ☐ *Trifocal:* | | Lens Coating/Lens Tint | |
| ☐ *Polycarbonate* | ☐ *Aphakic:* | | | |
| ☐ *Other* | | | | |

SCRATCH COAT: ☐

## FRAME INFORMATION

☐ SUPPLY ☐ LENSES ONLY ☐ EPSDT ☐ 2ND PR S.V. ☐ Rx CHANGE

☐ ZYL ☐ METAL ☐ GROOVE ☐ HALF EYE

| Frame Name | Color | Eye Size | Bridge | Temple |
|---|---|---|---|---|
| | | | ☐ AP ☐ FF | ☐ SK ☐ CC |

| Manufacturer | Frame or Pattern # | Frame Measurements A: | B: | ED: | Shape Code | Circumference |
|---|---|---|---|---|---|---|
| | | | | | | |

NOTE: A copy of the recipient's medicaid card must be attached to the Rx order.

| Reimbursement By | Provider | State |
|---|---|---|
| Lenses | | |
| Frame | | |
| Photo-Chromic | | |
| Tint | | |
| Ultra Violet | | |
| Scratch Coat | | |

| TRAY # | PROVIDER NO. | TOTAL |
|---|---|---|
| | | |

**1 Copy - Provider 1 Copy - Lab File 1 Copy - Return with Eyeware**